



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BODIES IN BALANCE
4151 SW FREEWAY STE 210
HOUSTON TX 77027

Respondent Name

Texas Mutual Insurance

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1572-01

MFDR Date Received

January 12, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim open & compensable."

Amount in Dispute: \$1,249.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The requested billed 99214 for date 2/17/11. Texas Mutual inadvertently paid this on 3/15/11. 2. The requestor billed 90801 for a psychiatric interview on 3/22/11. TMI has disputed the compensability of psychological issues. For that reason payment was declined as unrelated. 3. In order to resolve the fee dispute for code 97750 billed by the requestor for date 5/16/11 Texas Mutual will pay the disputed service. 4. The requestor billed code 99214 for dates 6/10/11 and 6/24/11. Texas Mutual denied payment because the documentation does not meet the requirements of the code."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2011	99214	\$1,249.00	\$101.00
May 16, 2011	97750		
March 22, 2011	90801		
June 10, 2011	99214		
June 24, 2011	99214		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.202 sets out medical fee guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-219 – “BASED ON EXTENT OF INJURY
 - 246 – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY
 - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED.
 - 738 – FCE ALLOWED A MAX OF 3 TIMES PER INJURY (EXCEPT DWC ORDERED) INITIAL = MAX OF 4 HRS; INTERIM = MAX OF 2 HOURS; DISCHARGE = MAX OF 3 HRS.
 - 890 – DENIED PER AMA CPT CODE DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS
 - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
 - 150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.

Issues

1. Did the requestor resolve the compensability issue for dates of service in dispute March 22, 2011?
2. Did the requestor support the E&M codes that are in dispute?
3. Is the respondent's denial of Functional Capacity Evaluation supported?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied dates of service March 22, 2011 as CAC-219 – “BASED ON EXTENT OF INJURY and 246 – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. The dates of service reference above contain unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

Dispute resolution sequence: 28 Texas Administrative Code §133.05(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307 (c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, dates of service March 22, 2011 were not considered in this review.

2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed one chronic condition, thus not meeting this component.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed three systems, this component was not met.
 - Past Family, and/or Social History (PFSH) require at least one specific item from any three

history areas to be documented. The documentation found none. This component was not met.

- Documentation of a Detailed Examination:
 - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed three body/organ systems: Back, Neck, Constitutional. This component was not met.

The division concludes that the documentation does not sufficiently support the level of service billed.

3. The carrier denied disputed service 97750 as 738 – “FCE ALLOWED A MAX OF 3 TIMES PER INJURY (EXCEPT DWC ORDERED) INITIAL = MAX OF 4 HRS; INTERIM = MAX OF 2 HOURS; DISCHARGE = MAX OF 3 HRS.” Review of submitted documentation titled, “Functional Capacity Evaluation” finds elements set out in 134.202 4(A) have been met. Therefore, this service will be reviewed per applicable rules and fee guidelines.
4. Review of the submitted documentation finds the following: 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or:

Date of Service	Code	Finding
February 7, 2011	99214	Paid by carrier at requested amount no additional payment recommended
May 16, 2011	97750	Maximum allowed per rule for interim evaluation is two hours or two units $(54.54 / 33.9764) \times 31.46 = \$50.50 \times 2 \text{ units} = \101.00
March 22, 2011	90801	Not eligible for review
June 10, 2011	99214	Documentation does not support EM code that was submitted. No payment recommended
June 24, 2011	99214	Documentation does not support EM code that was submitted. No payment recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$101.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$101.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.